DAVID K. NANCE, DDS
285 East 400 South, Springville, UT 84663
Phone: (801) 489-1000

PATIENT INFORMATION (MINOR)

Patient Name: ______________________________

Address: ______________________ P.O. Box: ______________

City: ______________ State: ______________ Zip: ______________

☐ Male ☐ Female Age: ________ Nickname: ______________

Home Phone: ______________ Cell Phone: ______________ Email: ______________

Would you like to have your appointment reminders by email or text message? ______________

Birth Date: ______________ Social Security# ______________

Minor Living With: ☐ Both Natural Parents ☐ Natural Mother ☐ Natural Father ☐ Other ______________

School Attending: ______________________________

City: ______________________ State: ______________

In case of emergency, please notify my nearest relative or acquaintance not living with me.

Name: ______________________________

Address: ______________________________

Phone: ______________ Relationship: ______________

Person Responsible for Payment of this Account

Name of Responsible Party: ______________ Relationship: ______________

Address: ______________________ P.O. Box: ______________

City: ______________ State: ______________ Zip: ________ AGE: ________

Home Phone: ______________ Cell Phone: ______________ Email: ______________

Birth Date: ______________ Social Security# ______________ Driver's Lic.# ______________

Employer: ______________________ Employer Phone # : ______________

Employer Address: ______________ City: ______________ State: ________ Zip: ______________

Will dental insurance be involved: ______________________ If yes, please complete next section.

Patient Insurance information (Use your ID card)

Subscriber's Name: ______________ Subscriber's Address: ______________

Subscriber's #: ______________ Subscriber's Birthdate: ______________

Subscriber's SS#: ______________ Relationship to Insured: ______________

Name of Insurance Company: ______________ Group#: ______________ ID#: ________

Address to send claims: ______________________________

Subscriber's Employer: ______________________ Employer Phone # : ______________

Effective Date: ______________ Do you carry secondary insurance: ________ If yes, complete next section.

Secondary Insurance information (Use your ID card)

Subscriber's Name: ______________ Subscriber's Address: ______________

Subscriber's #: ______________ Subscriber's Birthdate: ______________

Subscriber's SS#: ______________ Relationship to Insured: ______________

Name of Insurance Company: ______________ Group#: ______________ ID#: ________

Address to send claims: ______________________________

Subscriber's Employer: ______________________ Employer Phone # : ______________

Effective Date: ______________